APPENDIX 12
MEDICAL DAY TREATMENT DEMOGRAPHIC AND CLIENT INFORMATION COMPLETION INSTRUCTIONS

This form is the face sheet of the functional assessment scales which are required for clients in day treatment who are Wisconsin Medical Assistance recipients. This form must be completed by the day treatment staff before treatment begins, preferably by the client's case manager or by the primary staff person responsible for the person's treatment.

The form must be completed each time a functional assessment is performed. It should be kept in the client's case records. Also, a copy must be sent to the Wisconsin Medical Assistance Program (WMAP) at time of prior authorization request. Do not submit the form with claims for payment.

Print or type the information on the form, so that it is legible.

The numbers of the following items correspond to the numbers appearing on the sample form in Appendix 11 of this handbook.

1. Initial assessment/Reassessment: Check the appropriate space and indicate the date the functional assessment was performed.

2. Client has received...: Complete the statement by indicating the total number of hours of day treatment the recipient has received since the initial assessment.

3. Name: Print the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

4. Sex: Check the appropriate space.

5. Birthdate: Indicate the recipient's birthdate in MM/DD/YY format. For example, March 21, 1959, would be written as 03/21/59.

6. Address: Indicate the recipient's address. If the recipient resides in a nursing home or community based residential facility, indicate the name of the facility in addition to the address.

7. Telephone: Indicate the recipient's home telephone number.

8. Referral Source: Circle the appropriate number corresponding to the type of referral. Refer to the referral codes in item 29 of this form for descriptions of the referral codes. Indicate the name and address of the person or agency making the referral.

9. Telephone: Indicate the referral source's telephone number.

10. Prescribing Physician: Indicate the name and address of the prescribing or referring physician.

11. Telephone: Indicate the prescribing physician's telephone number.

12. Client Presently Hospitalized?/Living in a Nursing Home? Indicate whether the client presently is an inpatient in an acute care general hospital or in a psychiatric hospital, is a resident in a nursing home.

13. Name of Facility/Address: If you checked "yes" to either question in item 12 of this form, indicate the name and address of the facility.

14. Since.../Discharge Date: If you checked "yes" to either question in item 12 of this form, then indicate the date the recipient became an inpatient or resident of the facility. Also indicate the anticipated discharge date (obtained from the facility).

15. Usual Living Arrangement: Check the appropriate space corresponding to the recipient's usual living arrangement.

16. Medicaid #/SSIS #/TIS #: Indicate the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

    If the recipient is receiving Title XX social services through the county social services department, the recipient will have an Social Services Information System (SSIS) number. If you don't know the number, but you know the person is receiving social services (e.g., day care, supportive home care, foster care, etc.) through the county, contact the county social service office to find out the number.

    All recipients will have Transitional Information System (TIS) numbers. TIS numbers are the client identification numbers used by 51.42 boards in reporting to the Department of Health and Social Services on units of services provided in a quarterly reporting period. Each recipient in your program will have a TIS number.

17. Reason for Referral: State briefly the major reason(s) the person was referred to day treatment.

Items 18 through 24 Eligibility Decision Criteria: The information requested in items 18 though 24 of this form makes up the summary of data obtained through performing the complete functional assessment (pages 2-5). Based on the information contained in this section, the recipient may or may not be eligible for Medical Assistance reimbursement of the day treatment services. See the "Decision Rules for Day Treatment" for a full explanation of the criteria for eligibility.

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18. AODA Currently: Does the recipient currently exhibit dependence on or abuse of alcohol or other drugs? Check the appropriate answer.

19. MR Primary Diagnosis: Does the recipient have a primary diagnosis of mental retardation? Mental retardation is defined as anyone with a diagnosis of 317, 318, or 319, according to the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9).

20. ICD-9 Primary/Secondary Diagnosis: List the primary and secondary diagnoses according to the ICD-9. Do not use any other coding structure.

21. Total Score LOF: Indicate the three scores from the functional assessment scales in the following order: 1) Task Orientation Scale, 2) Social Functioning Scale, and 3) Emotional Functioning Scale. Then add the scores for the total level of functioning (LOF) score. The score for each scale is the number of the set of statements which best describes the recipient's level of functioning.

22. Likelihood of Benefit: Indicate the answer from page 5, question 5, of the functional assessment scales.

23. Course of Functioning Score: Indicate the answer from page 5, question 6, of the functional assessment scales. The course of functioning score is the sum of the scores for Parts A-E.

24. Risk of Hospitalization: Indicate the answer from page 5, question 7, of the functional assessment scales. This item does not need to be completed unless the answer to item 23 of this form was between 13 and 25.

25. Current Services Being Received: Indicate any services the recipient is receiving in addition to day treatment. For example, is the recipient receiving psychotherapy or occupational therapy in addition to day treatment from your facility? Does the recipient attend a sheltered workshop? Does the recipient receive social work services from the county? Does the recipient have a guardian or advocate? These are the types of services (both medical and nonmedical) that should be indicated. If this information is not known, check with the referral source, the county social service office, or the recipient's place of residence.

26. Name of Day Treatment Program/Signatures: Print the name of the day treatment program. The person performing the functional assessment (e.g., case manager or primary staff person) must sign and indicate his or her discipline. The day treatment program director must also sign after reviewing the assessment form.

27. Authorization: (not required)

28. Approval Given For: (not required)

29. Referral Source Code: These are the descriptions of the codes used in item 8 of this form.